

# **APPENDIX E**

## **REGULATIONS**

CALIFORNIA CODE OF REGULATIONS

TITLE 22

DIVISION 7

CHAPTER 10  
HEALTH FACILITY DATA

ARTICLE 8  
DISCHARGE DATA REPORTING REQUIREMENTS

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## **97210. Notice of Change in Hospital Operations, Contact Person, Method of Submission or Designated Agent.**

(a) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in the person designated as the patient discharge contact person or in the telephone number of the contact person.

(b) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in method of submission or change in designated agent for the purpose of submitting the hospital's discharge data report. If there is a change in designated agent, the hospital or its new designated agent must comply with Section 97215. A hospital may submit its own discharge data report directly to the Office's Discharge Data Program, or it may designate an agent for this purpose.

(c) Each hospital beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Discharge Data Program within 30 days after its first day of operation of its: designated agent for the purpose of submitting the hospital's discharge data report (if it chooses not to submit its discharge data report directly), method of submission, contact person, and telephone number of contact person. The hospital shall be provided a unique identification number that it can report pursuant to Section 97239. Pursuant to Section 97215, the hospital, if it chooses to designate itself to submit its discharge data report, and its method of submission is not Manual Abstract Reporting Form (OSHPD 1370), shall submit a set of test data that is in compliance with the required format. Pursuant to Section 97215, any agent the hospital designates to submit its discharge data report on its behalf must have submitted a test set of data that is in compliance with the required format, prior to the due date of the hospital's first reporting period.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97211. Reporting Periods and Due Dates.**

(a) The prescribed reporting period is calendar semiannual, which means that there are two reporting periods each year, consisting of discharges occurring January 1 through June 30 and discharges occurring July 1 through December 31. The prescribed due dates are six months after the end of each reporting period; thus, the due date for the January 1 through June 30 reporting period is December 31 of the same year, and the due date for the July 1 through December 31 reporting period is June 30 of the following year.

(b) Where there has been a change in the licensee of a hospital, the effective date of the change in licensee shall constitute the start of the reporting period for the new licensee, and this first reporting period shall end on June 30 or December 31, whichever occurs first. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective, and the due date for the discharge data report shall be six months after the final day of this reporting period.

(c) Discharge data reports shall be filed, as defined by Section 97005, by the date the discharge data report is due. Where a hospital has been granted an extension, pursuant to Section 97241, the

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ending date of the extension shall constitute the new due date for that discharge data report.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97212. Definitions, as used in this Article.**

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code.

(b) Computer Media. Computer media means computer tape (reel or cartridge), diskette, or compact disk.

(c) Designated Agent. An entity designated by a hospital to submit that hospital's discharge data records to the Office's Discharge Data Program; may include the hospital's abstractor, a data processing firm, or the data processing unit in the hospital's corporate office.

(d) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one type of care to another type of care, as defined by Subsection (i) of Section 97212, or

(3) has died.

(e) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Healthcare Financing Administration.

(f) Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.

(g) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Healthcare Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

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(h) Method of Submission. A method of submission is the medium used by a hospital or its designated agent to submit a discharge data report to the Office and may be one of the following:

- (1) computer tape (reel or cartridge),
- (2) diskette,
- (3) compact disk, or
- (4) Manual Abstract Reporting Form (OSHPD 1370).

(i) Type of Care. Type of care is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by Subdivisions (a)(2), (a)(3), or (a)(4), of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. included on a hospital's license within the general acute care classification, as defined by Subdivision Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds (a)(1) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and of Section 70595.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds, as defined by Subdivision (a)(5) of Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by Subdivision (a)(7) of Section 1250.1 and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, as defined by Subdivision (a)(1) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than those defined by Subsections (i)(1), (i)(2), (i)(3), and (i)(4) of this section.

(j) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of Section 128700 of the Health and Safety Code.

(k) Record. A record is defined as the set of data elements of the "hospital discharge abstract data

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record,” as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for one patient.

(l) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period or for a shorter period, pursuant to Subsection (b) of Section 97211.

Authority: Section 128810, Health and Safety Code.

Reference: Sections 128735, 1250, and 1250.1, Health and Safety Code.

## **97213. Required Reporting.**

(a) Each hospital shall submit the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the acute care type of care, as defined by Subsection (i)(5) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHDP 1370), the hospital shall identify these records by recording a “1” in the space provided. If submitted on computer media, the hospital shall identify these records by recording a “1” in the first position on each of these records.

(c) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care type of care, as defined by Subsection (i)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHDP 1370), the hospital shall identify these records by recording a “3” in the space provided. If submitted on computer media, the hospital shall identify these records by recording a “3” in the first position on each of these records.

(d) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the psychiatric care type of care, as defined by Subsection (i)(3) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHDP 1370), the hospital shall identify these records by recording a “4” in the space provided. If submitted on computer media, the hospital shall identify these records by recording a “4” in the first position on each of these records.

(e) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the chemical dependency recovery care type of care, as defined by Subsection (i)(4) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHDP 1370), the hospital shall identify these records by recording a “5” in the space provided. If submitted on computer media, the hospital shall identify these records by recording a “5” in the first position on each of these records.

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(f) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the physical rehabilitation care type of care, as defined by Subsection (i)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "6" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "6" in the first position on each of these records.

(g) Each discharge data report shall be submitted at one time, use one method of submission, and shall include all types of care.

(h) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

(i) If a hospital operating under a consolidated license submits its report in separate sets of records, the compilation of those sets must include all discharge records from all types of care and from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's discharge data report for purposes of this Article.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97214. Form of Authentication.**

(a) Hospitals submitting their hospital discharge abstract data records using the Manual Abstract Reporting Forms (OSHPD 1370) must submit with each discharge data report a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as specified in Section 97239, the reporting period's beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: \_\_\_\_\_  
\_\_\_\_\_  
(Name of hospital)

By: \_\_\_\_\_

Title: \_\_\_\_\_

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Address: \_\_\_\_\_

A hospital that uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

(b) Hospitals submitting their hospital discharge abstract data records using computer media ~~must~~ submit with each discharge data report a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as specified in Section 97239, the reporting period's beginning and ending dates, the number of records, the tape specifications, and the signed statement of certification, as specified in Subsection (a) of Section 97214.

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records must submit for each discharge data report a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each reporting period, and before that corresponding reporting period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, that contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: \_\_\_\_\_  
\_\_\_\_\_  
(Name of hospital)

By: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each discharge data report a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: the hospital name, the hospital identification number, the reporting period's beginning and ending dates, the number of records, and the tape specifications. If the computer tape contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.



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Designated agents are not required to submit any certification forms.

(e) Any hospital or designated agent may obtain free copies of the Individual Hospital Transmittal form (OSHPD 1370.1), the Agent's Transmittal Form (OSHPD 1370.2), and the Discharge Data Certification Form (OSHPD 1370.3) by contacting the Office's Discharge Data Program.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97215. Format.**

Patient discharge data shall be reported to the Office's Discharge Data Program on either the Manual Abstract Reporting Form (OSHPD 1370) or on computer media. The version of the Manual Abstract Reporting Form (OSHPD 1370) to be used depends on the date of discharge: discharges January 1, 1997, through December 31, 1998, shall use Form 1370 as revised June 1996, and discharges on or after January 1, 1999, shall use Form 1370 as revised in March 1998. The Office shall furnish each hospital using Form 1370 a copy of the appropriate version in advance of the start of each reporting period. Additional copies of Form 1370 shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

The format and specifications for the computer media depend on the date of discharge: discharges January 1, 1997, through December 31, 1998, shall comply with the Office's standard format and specifications as revised September 1, 1995, and discharges on or after January 1, 1999, shall comply with the Office's standard format and specifications as revised in March 1998. The Office shall furnish each hospital and designated agent a copy of the standard format and specifications before the start of the reporting period to which revisions apply. Additional copies may be obtained at no charge from the Office's Discharge Data Program.

Each hospital whose discharge data is submitted on computer media or, if the hospital has designated an agent, that agent, shall demonstrate its ability to comply with the standard format and specifications by submission of a test file of its data with which the Office can confirm compliance with the standard format and specifications.

The test file shall be submitted at least 60 days prior to the next reporting period due date by new hospitals or by existing hospitals after a change in any of the following: the Office's standard format and specifications; the hospital's or its designated agent's computer system, hardware or software; the computer media used by the hospital or its designated agent, the method of submission; or the designated agent, unless the new designated agent has already submitted a test file that complied with the standard format and specifications.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97216. Definition of Data Element—Date of Birth.**

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the

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2-digit day, and the 4-digit year of birth. The numeric form for days and months from 1 to 9 must have a zero as the first digit. When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported. If the month and year of birth are known, and the exact day is not, the year, the month, and zeros for the day shall be reported.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97217. Definition of Data Element—Sex.**

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was not available from the medical record.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97218. Definition of Data Element—Race.**

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and one choice from the following list of alternatives under race:

### **(a) Ethnicity:**

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

### **(b) Race:**

(1) White. A person having origins in or who identifies with any of the original caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

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(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

(5) Other. Any possible options not covered in the above categories.

(6) Unknown.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

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## **97219. Definition of Data Element—ZIP Code.**

The “ZIP Code,” a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient’s usual residence shall be reported for each patient discharge. Foreign residents shall be reported as “YYYYY” and unknown ZIP Codes shall be reported as “XXXXX.” If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals shall distinguish the “homeless” (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as “ZZZZZ.” If the patient has a 9-digit ZIP Code, only the first five digits shall be reported.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97220. Definition of Data Element—Patient Social Security Number.**

The patient’s social security number is to be reported as a 9-digit number. If the patient’s social security number is not recorded in the patient’s medical record, the social security number shall be reported as “not in medical record,” by reporting the social security number as “000000001.” The number to be reported is to be the patient’s social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital’s bill is to be submitted.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97221. Definition of Data Element—Admission Date.**

The patient’s date of admission shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (i) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

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## **97222. Definition of Data Element—Source of Admission.**

Effective with discharges on or after January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(a) The site from which the patient was admitted.

(1) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(2) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(3) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(4) Skilled Nursing/Intermediate Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

(5) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of a hospital.

(6) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(7) Newborn. A baby born alive in this hospital.

(8) Prison/Jail. A patient admitted from a correctional institution.

(9) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from a freestanding, not hospital-based, inpatient hospice facility.

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## (b) Licensure of the site.

(1) This Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(2) Another Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Skilled Nursing/Intermediate Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

## (c) Route of admission.

(1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of another hospital.

(2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

### **97223. Definition of Data Element—Type of Admission.**

Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of the following categories:

(a) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

(b) Unscheduled. Admission was not arranged with the hospital at least 24 hours prior to the admission.

(c) Infant. An infant less than 24 hours old.

(d) Unknown. Nature of admission not known. Does not include stillbirths.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

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## **97224. Definition of Data Element—Discharge Date.**

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97225. Definition of Data Element—Principal Diagnosis and Whether the Condition was Present at Admission.**

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(b) Effective with discharges on or after January 1, 1996, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97226. Definition of Data Element—Other Diagnoses and Whether the Conditions were Present at Admission.**

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

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(b) Effective with discharges on or after January 1, 1996, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

- (1) Yes.
- (2) No.
- (3) Uncertain.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97227. Definition of Data Element—External Cause of Injury.**

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97228. Definition of Data Element—Principal Procedure and Date.**

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for



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days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97229. Definition of Data Element—Other Procedures and Dates.**

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97230. Definition of Data Element—Total Charges.**

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97231. Definition of Data Element—Disposition of Patient.**

Effective with discharges on or after January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported as one of the following:

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic shall be included. Excludes patients referred to a home health service.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric,

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physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(i) Prison/Jail. A patient discharged to a correctional institution.

(j) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from away without leave (AWOL) status are included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

(m) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a freestanding, not hospital-based, inpatient hospice facility.

## **97232. Definition of Data Element—Expected Source of Payment.**

(a) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

(1) Payer Category: The type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill.

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(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (a)(1)(A), (a)(1)(B), (a)(1)(D), or (a)(1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (a)(1)(E) of this section.

(H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

(I) Other Payer. Any third party payment not included in Subsections (a)(1)(A) through (a)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(2) Type of Coverage. For each Payer Category, Subsections (a)(1)(A) through (a)(1)(F) of this section, select one of the following Types of Coverage:

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

(B) Managed Care - Other. Health care plans, except those in Subsection (a)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or

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per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

(C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

## (3) Name of Plan.

(A) For discharges occurring on or after January 1, 1999, up to and including discharges occurring on December 31, 1999, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan as shown in Table 1. or the Medi-Cal County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers:  
For use with discharges occurring in 1999

| Plan Code Names                               | Plan Code Numbers |
|---|-------------------|
| Aetna Health Plans of California, Inc.        | 0176              |
| Alameda Alliance for Health                   | 0328              |
| American Family Care                          | 0322              |
| Blue Cross of California                      | 0303              |
| Blue Shield of California                     | 0043              |
| BPS HMO                                       | 0314              |
| Brown and Toland Medical Group                | 0352              |
| Calaveras Provider Network                    | 0365              |
| Care 1st Health Plan                          | 0326              |
| Careamerica-Southern California, Inc.         | 0234              |
| Chinese Community Health Plan                 | 0278              |
| Cigna Healthcare of California, Inc.          | 0152              |
| Community Health Group                        | 0200              |
| Community Health Plan (County of Los Angeles) | 0248              |
| Concentrated Care, Inc.                       | 0360              |
| Contra Costa Health Plan                      | 0054              |
| FPA Medical Management of California, Inc     | 0350              |
| Great American Health Plan                    | 0327              |
| Greater Pacific HMO Inc                       | 0317              |
| HAI   | 0292              |
| Healthmax America                             | 0277              |
| Health Net                                    | 0300              |
| Health Plan of America (HPA)                  | 0126              |
| Health Plan of the Redwoods                   | 0159              |

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|---|------|
| Heritage Provider Network, Inc.                 | 0357 |
| Inland Empire Health Plan                       | 0346 |
| Inter Valley Health Plan                        | 0151 |
| Kaiser Foundation Added Choice Health Plan      | 0289 |
| Kaiser Foundation Health Plan, Inc.             | 0055 |
| Kern Health Systems Inc                         | 0335 |
| Key Health Plan of California                   | 0343 |
| Lifeguard, Inc.                                 | 0142 |
| LA Care Health Plan                             | 0355 |
| Managed Health Network                          | 0196 |
| Maxicare  | 0002 |
| MCC Behavioral Care of California, Inc.         | 0298 |
| MedPartners Provider Network, Inc.              | 0345 |
| Metrahealthcare Plan                            | 0266 |
| Merit Behavioral Care of California, Inc.       | 0288 |
| Monarch Plan Inc.                               | 0270 |
| National Health Plans                           | 0222 |
| National HMO                                    | 0222 |
| Occupational Health Services (OHS)              | 0235 |
| Omni Healthcare, Inc.                           | 0238 |
| One Health Plan of California Inc.              | 0325 |
| Pacificare Behavioral Health of California Inc. | 0301 |
| Pacificare of California                        | 0126 |
| Priorityplus of California                      | 0237 |
| Prucare Plus                                    | 0296 |
| Qualmed Plans for Health                        | 0300 |
| Regents of the University of California         | 0354 |
| San Francisco Health Plan                       | 0349 |
| Santa Clara County Family Health Plan           | 0351 |
| Secure Horizons                                 | 0126 |
| Sharp Health Plan                               | 0310 |
| Smartcare Health Plan                           | 0212 |
| The Health Plan of San Joaquin                  | 0338 |
| Tower Health Service                            | 0324 |
| UHC Healthcare                                  | 0266 |
| UHP Healthcare                                  | 0008 |
| Universal Care                                  | 0209 |
| Valley Health Plan                              | 0236 |
| Value Behavioral Health of California, Inc.     | 0293 |
| Ventura County Healthcare Plan                  | 0344 |
| Vista Behavioral Health Plan                    | 0102 |
| Western Health Advantage                        | 0348 |

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|       |      |
|-------|------|
| Other | 8000 |
|-------|------|

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers:  
For use with discharges occurring in 1999

| Name of Medi-Cal County Organized Health System       | Plan Code Numbers |
|---|-------------------|
| Cal Optima (Orange County)                            | 9030              |
| Health Plan of San Mateo (San Mateo County)           | 9041              |
| Santa Barbara Health Authority (Santa Barbara County) | 9042              |
| Santa Cruz County Health Options (Santa Cruz County)  | 9044              |
| Solano Partnership Health Plan (Solano County)        | 9048              |

(B) For discharges occurring on or after January 1, 2000, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan as shown in Table 1. or the Medi-Cal County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers:  
For use with discharges occurring in 2000

| Plan Code Names                               | Plan Code Numbers |
|---|-------------------|
| Aetna Health Plans of California, Inc.        | 0176              |
| Alameda Alliance for Health                   | 0328              |
| Blue Cross of California                      | 0303              |
| Blue Shield of California                     | 0043              |
| BPS HMO                                       | 0314              |
| Calaveras Provider Network                    | 0365              |
| Care 1st Health Plan                          | 0326              |
| Cedars-Sinai Provider Plan, LLC               | 0366              |
| Chinese Community Health Plan                 | 0278              |
| Cigna Healthcare of California, Inc.          | 0152              |
| Community Health Group                        | 0200              |
| Community Health Plan (County of Los Angeles) | 0248              |
| Concentrated Care, Inc.                       | 0360              |
| Contra Costa Health Plan                      | 0054              |
| FPA Medical Management of California, Inc     | 0350              |
| Great American Health Plan                    | 0327              |
| Greater Pacific HMO Inc                       | 0317              |
| HAI, Hai-Ca                                   | 0292              |
| Healthmax America                             | 0277              |
| Health Net                                    | 0300              |
| Health Plan of America (HPA)                  | 0126              |

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| Health Plan of the Redwoods                                | 0159 |
| Health Plan of San Mateo <i>Healthy Families, not COHS</i> | 0358 |
| Heritage Provider Network, Inc.                            | 0357 |
| Holman Professional Counseling Centers                     | 0231 |
| Inland Empire Health Plan                                  | 0346 |
| Inter Valley Health Plan                                   | 0151 |
| Kaiser Foundation Added Choice Health Plan                 | 0289 |
| Kaiser Foundation Health Plan, Inc.                        | 0055 |
| Kern Health Systems Inc                                    | 0335 |
| Key Health Plan of California                              | 0343 |
| Key HMO Key Choice   | 0343 |
| Lifeguard, Inc.  | 0142 |
| LA Care Health Plan  | 0355 |
| Managed Health Network                                     | 0196 |
| Maxicare   | 0002 |
| MCC Behavioral Care of California, Inc.                    | 0298 |
| MedPartners Provider Network, Inc.                         | 0345 |
| Metrahealth Care Plan                                      | 0266 |
| Merit Behavioral Care of California, Inc.                  | 0288 |
| Molina   | 0322 |
| National Health Plans                                      | 0222 |
| National HMO   | 0222 |
| Omni Healthcare, Inc.                                      | 0238 |
| One Health Plan of California Inc.                         | 0325 |
| On Lok Senior Health Services                              | 0385 |
| Pacificare Behavioral Health of California Inc.            | 0301 |
| Pacificare of California                                   | 0126 |
| Primecare Medical Network, Inc. A CA. Corp.                | 0367 |
| Priorityplus of California                                 | 0237 |
| Prucare Plus   | 0296 |
| Qualmed Plans for Health/Bridgeway                         | 0300 |
| Regents of the University of California                    | 0354 |
| San Francisco Health Plan                                  | 0349 |
| Santa Clara Family Health Plan                             | 0351 |
| Scripps Clinic Health Plan Services, Inc.                  | 0377 |
| Secure Horizons  | 0126 |
| Sharp Health Plan  | 0310 |
| Simnsa Health Care   | 0393 |
| Sistemas Medicos Nacionales, S.A. De C.V.                  | 0393 |
| Smartcare Health Plan                                      | 0212 |
| The Health Plan of San Joaquin                             | 0338 |
| Thipa Management Consultants, Incorporated                 | 0363 |

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|   |      |
|---|------|
| Tower Health Service                        | 0324 |
| UHC Healthcare                              | 0266 |
| UHP Healthcare                              | 0008 |
| Universal Care                              | 0209 |
| Valley Health Plan                          | 0236 |
| Value Behavioral Health & American Psychol. | 0293 |
| Ventura County Health Care Plan             | 0344 |
| Vista Behavioral Health Plan                | 0102 |
| Western Health Advantage                    | 0348 |
| Other                                       | 8000 |

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers  
for use with discharges occurring in 2000

| Name of Medi-Cal County Organized Health System       | Plan Code Numbers |
|---|-------------------|
| Cal Optima (Orange County)                            | 9030              |
| Health Plan of San Mateo (San Mateo County)           | 9041              |
| Santa Barbara Health Authority (Santa Barbara County) | 9042              |
| Central Coast Alliance For Health (Santa Cruz County) | 9044              |
| Solano Partnership Health Plan (Solano County)        | 9048              |

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97233. Definition of Data Element—Prehospital Care and Resuscitation.**

Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

- (a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.
- (b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97239. Hospital Identification Number.**

Effective with discharges on or after January 1, 1995, the last six digits of the 9-digit identification number assigned by the Office shall be reported as part of each patient record, either in the specified section of the Manual Abstract Reporting Form (OSHDP 1370) or in positions 2 through 7 on



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computer media format.

Authority: Section 128765, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97240. Request for Modifications to the California Hospital Discharge Data Set.**

(a) Hospitals may file a request with the Office for modifications to the California Hospital Discharge Data Set. The modification request must be supported by a detailed justification of the hardship that full reporting of discharge data would have on the hospital; an explanation of attempts to meet discharge data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each hospital with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to discharge data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed healthcare decisions.

(2) The modification would not deprive the public of discharge data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

Authority: Section 128810, Health and Safety Code.

Reference: Sections 128735 and 128760, Health and Safety Code.

## **97241. Requests for Extension of Time to File Discharge Data.**

Extensions are available to hospitals that are unable to complete their submission of discharge data reports by the due date prescribed in Section 97211. A maximum of 60 days is allowed for all extensions, corrections, and resubmittals. Hospitals are encouraged to file extension requests as soon as it is apparent that the required data will not be completed for submission on or before their due date. The request for extension shall be postmarked on or before the required due date of the discharge data report and supported by a letter of justification that may provide good and sufficient cause for the approval of the extension request. To provide the Office a basis to determine good and sufficient cause, the letter of justification shall include a factual statement indicating:

(1) the actions taken by the hospital to produce the discharge data report by the required deadline;

(2) those factors that prevent completion of the discharge data report by the deadline; and

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(3) those actions and the time (days) needed to accommodate those factors.

The Office shall respond within 10 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice to the hospital sent by certified mail. The Office may seek additional information from the requesting hospital. The Office shall not grant extensions that exceed an accumulated total of 60 days for all extensions and corrections of discharge data. If a hospital submits the discharge data report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A hospital that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

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## 97242. Error Tolerance Levels.

(a) The error tolerance levels for discharge data items reported to the Office shall be as shown in Table 1. An error percentage that exceeds a specified error tolerance level shall be corrected by the hospital to the specified tolerance level.

(b) For error percentages for the data elements Admission Date and Discharge Date that do not exceed the error tolerance levels specified in Table 1, the Office shall delete each record with an error in one of these data elements from the hospital's report if the hospital fails to correct the data after a 30 calendar day notification by the Office of the errors.

(c) Effective with discharges occurring on or after July 1, 1990, for error percentages for data elements other than Admission Date and Discharge Date that do not exceed the error tolerance levels specified in Table 1, the Office shall assign default values of blank, which may be represented by a zero, except that for the data element Whether the Condition was Present at Admission for the Principal Diagnosis the Office shall assign the default value of Yes, if the hospital fails to correct the data after a 30 calendar day notification by the Office of the errors.

Table 1. Discharge Data Error Tolerance Levels

| Data Element   | Error Tolerance Level |
|--|-----------------------|
| Date of Birth  | .1%                   |
| Sex  | .1%                   |
| Race   | 5%                    |
| ZIP Code   | 5%                    |
| Patient Social Security Number                         | .1%                   |
| Admission Date   | .1%                   |
| Source of Admission                                    | 5%                    |
| Type of Admission                                      | 5%                    |
| Discharge Date   | .1%                   |
| Principal Diagnosis                                    | .1%                   |
| Condition Present at Admission for Principal Diagnosis | .1%                   |
| Other Diagnoses  | .1%                   |
| Condition Present at Admission for Other Diagnoses     | .1%                   |
| External Cause of Injury                               | .1%                   |
| Principal Procedure                                    | .1%                   |
| Principal Procedure Date                               | 1%                    |
| Other Procedures                                       | .1%                   |
| Other Procedures Dates                                 | 1%                    |
| Total Charges  | .1%                   |
| Disposition of Patient                                 | 1%                    |
| Expected Source of Payment                             | .1%                   |
| Prehospital Care and Resuscitation                     | .1%                   |

(d)(1) The error percentage for the data element Sex shall include unknown sex.

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- (2) The error percentage for the data element Race shall include unknown race.
- (3) The error percentage for the data element ZIP Code shall include partial and unknown ZIP codes.
- (4) The error percentage for the data element Type of Admission shall include unknown type of admission.
- (5) The error percentages for the data elements Principal Diagnosis and Other Diagnoses shall, for any one record, count all errors made in coding diagnoses as one error.
- (6) The error percentages for the data elements Condition Present at Admission for Principal Diagnosis and Condition Present at Admission for Other Diagnoses shall, for any one record, count all errors made as one error.
- (7) The error percentages for the data elements Principal Procedure and Other Procedures shall, for any one record, count all errors made in coding procedures as one error.
- (8) The error percentages for the data elements Principal Procedure Date and Other Procedures Dates shall, for any one record, count all errors made as one error.
- (9) The error percentage for the data element External Cause of Injury shall, for any one record, count all errors made in coding diagnoses as one error.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

## **97243. Acceptance Criteria.**

- (a) The discharge data report shall not be accepted but shall be rejected and returned to the hospital by the Office if the following requirements are not met:
  - (1) Submission of a completed transmittal form with the discharge data report, pursuant to Section 97214.
  - (2) Compliance with the Office's standard format and specifications, demonstrated by the hospital or its designated agent having previously submitted a set of data that the Office approved as being in conformance to the applicable standard format and specifications, pursuant to Section 97215.

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(3) Submission of the appropriate version of the Manual Abstract Reporting Form (OSHPD 1370), as specified in Section 97215, when reporting other than on computer media.

(4) Submission by the hospital or by its designated agent in accordance with the most recent designation furnished by the hospital to the Office, pursuant to Section 97210.

(b) After a discharge data report is accepted, the hospital may be required to correct and/or replace the data if any of the following circumstances pertain:

(1) The Office is unable to read the computer media submitted.

(2) When the computer medium data file is read, it contains no data, contains data not covering the full reporting period, or contains a different number of records in the file than the number of records stated on the transmittal form.

(3) The data are not reported in compliance with Section 97215.

(4) The hospital identification number on each of the records being reported for the hospital does not agree with that hospital's identification number specified on the transmittal form, pursuant to Section 97214.

(5) Corrections are required as a result of not meeting the requirements of Section 97213; not meeting the data element definitions, as specified in Sections 97216 through 97233; and/or not meeting the error tolerance levels, as specified in Table 1 of Section 97242.

(6) All inpatient discharges, as defined by Subsection (d) of Section 97212, were not reported.

(c) If a hospital is required to replace or correct their discharge data, the Office shall allow a specified number of days for correction or replacement and shall establish a due date for resubmittal of the corrections or replacement. In determining the number of days to be allowed, the Office shall take account of the number and degree of errors and the number of extension days already granted, but in no case shall an aggregate total of more than 60 days for all extensions, corrections, replacements, and resubmittals be allowed.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.